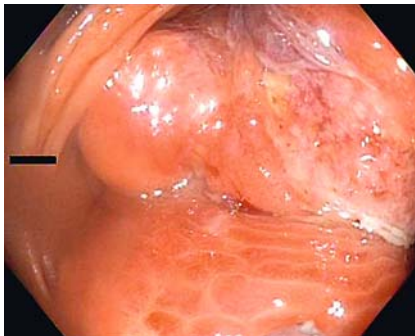


Endoscopic debulking of a large colonic lipoma causing recurrent intussusception using endoscopic mucosotomy technique

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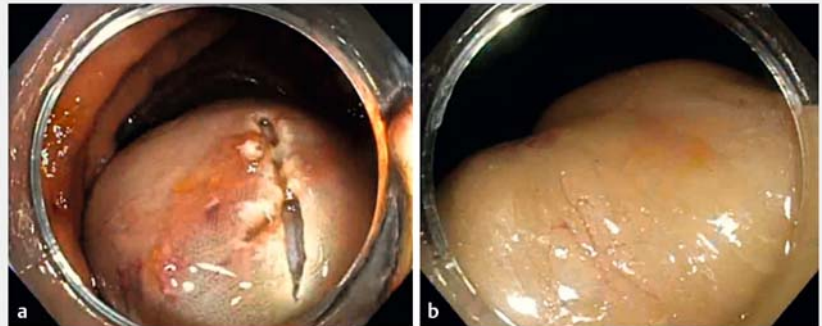


► **Fig. 1** Large lipoma obstructing the lumen of the ascending colon.

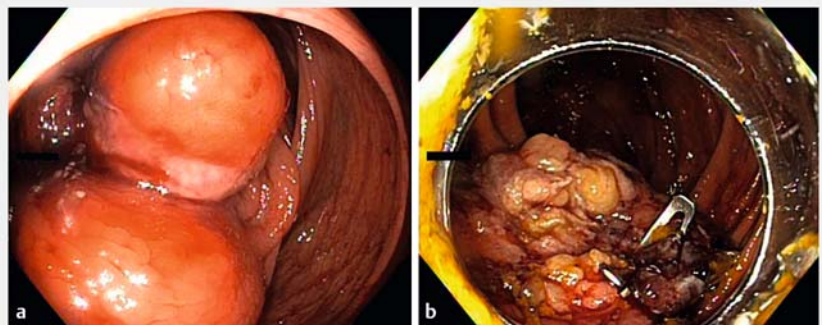
Colonic lipomas are usually incidental findings during colonoscopy. Lipomas ≥ 4 cm can cause obstruction and intussusception. Surgical resection is often recommended in these instances [1,2]. However, endoscopic resection of larger lipomas has been reported previously using PolyLoop-assisted unroofing technique, snare catheter unroofing/resection, and placement of endoclips prior to resection [3]. Here, we describe a novel technique for endoscopic debulking of a large colonic lipoma.

A 63-year-old man with a known large colonic lipoma causing recurrent intussusception presented with abdominal pain. He had previously declined surgery. Computed tomography scan of the abdomen demonstrated an 8-cm fat-containing mass in the ascending colon. Colonoscopy showed a large trilobed mass in the ascending colon with areas of ulceration, occluding the entire lumen of the colon (► **Fig. 1**). The patient refused surgery, and after multidisciplinary discussion, the decision was made to attempt endoscopic resection.

A colonoscopy was performed, and attempts to place a PolyLoop (Olympus, Tokyo, Japan) around the mass were unsuccessful due to the size and smoothness of the mass. Therefore, the decision was made to use an endoscopic submucosal dissection knife to perform a mucos-



► **Fig. 2** Endoscopic images. **a** The initial mucosal incision. **b** The exposed lipoma following mucosotomy.



► **Fig. 3** Endoscopic images. **a** The lipoma on index colonoscopy. **b** The colonic lumen after debulking of the lipoma.

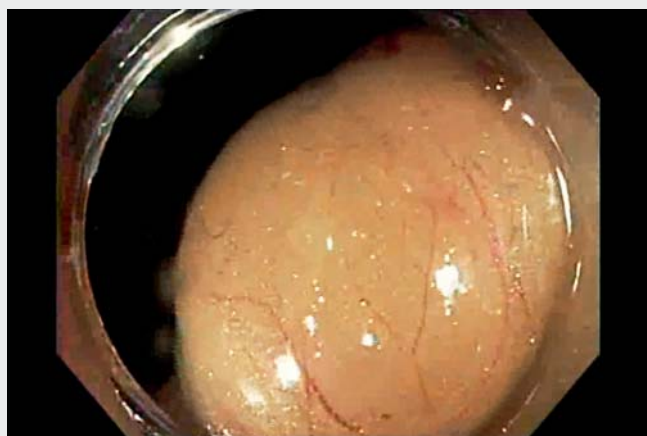
sal incision on the surface of the lesion to expose the underlying fatty tissue (► **Fig. 2a**). The lipoma was eventually exposed, and the fatty tissue was resected piecemeal with a snare (► **Fig. 2b**). The lipoma was significantly debulked with resolution of the patient's abdominal pain. Repeat colonoscopy was performed after 8 weeks, and the lesion was significantly smaller. Debulking was performed again using the same technique. As the size of the lesion was significantly reduced compared with the original lipoma, two PolyLoops could be successfully placed over the lesion, allowing sloughing of the remainder of the lesion.

Further colonoscopy after 6 months showed significant improvement in luminal narrowing (► **Fig. 3**, ► **Video 1**). The patient had no recurrence of intussusception at the 6-month follow-up.

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Video 1 Endoscopic debulking of a large colonic lipoma causing recurrent intussusception using endoscopic mucosotomy technique.

Bibliography

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Competing interests

The authors declare that they have no conflict of interest.

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